STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED 05/17/2012	
		155166	B. WIN			05/17/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND I	REHABILITATION CENTER		606 WA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
			17.00	.00		,	
	I	ode Recertification and	K00	100	The creation and submission this Plan of Correction does n		
		Survey was conducted by			constitute an admission by thi		
		e Department of Health in			provider of any conclusion set		
	accordance with	1 42 CFR 483.70(a).			forth in the statement of		
	Survey Date: 0:	5/17/12			deficiencies, or of any violation regulation.	n of	
	Facility Number	r: 000083			This provider respectfully requests that the 2567 Plan of	f	
	Provider Number	er: 155166			Correction be considered the		
	AIM Number:	100289670			Letter of Credible Allegation a		
					requests a Post Survey Revie on or after June 5, 2012.	W	
	Surveyor: Mark	Caraher, Life Safety			on or after surice 3, 2012.		
	Code Specialist	-					
	_						
	At this Life Safe	ety Code survey,					
		and Rehabilitation					
	_	nd not in compliance with					
		or Participation in					
	_	caid, 42 CFR Subpart					
		Safety from Fire and the					
	` ' '	the National Fire					
		ciation (NFPA) 101, Life					
		SC), Chapter 19, Existing					
		cupancies and 410 IAC					
		cupancies and 410 IAC					
	16.2.						
	This are stored	ogility was determined to					
	1	acility was determined to					
		11) construction and was					
		d. The facility has a fire					
	_	ith smoke detection in the					
		all areas open to the					
	corridor. The fa	acility does not have					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000083

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				01	(X3) DATE COMPL		
		155166	A. BUI B. WIN	LDING		05/17/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF P	PROVIDER OR SUPPLIER			606 WA			
VALPARAISO CARE AND REHABILITATION CENTER				VALPAF	RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		in resident rooms. The		1710	·		DATE
		acity of 168 and had a					
		the time of this survey.					
		Robert Booher, Life Safety dical Surveyor on 05/23/12.					
	The facility was	found not in compliance					
		entioned regulatory					
	requirements as						
	following:						

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155166	B. WIN			05/17/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.		606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	NFPA 101 LIFE SAFETY C One hour fire rat fire-rated doors) fire extinguishing 8.4.1 and/or 19.3 areas. When the extinguishing system are self-closing a protective plates inches from the permitted. 19.3  1. Based on obset the facility failed serving hazardou with fuel fired he close and latch in deficient practice resident, staff or the mechanical rore Respiratory Office.  Findings include  Based on observation maintenance Supplies the facility from on 05/17/12, the mechanical room gas fired water he Respiratory Office closing device, by floor and become	ODE STANDARD ed construction (with ¾ hour or an approved automatic g system in accordance with 3.5.4 protects hazardous e approved automatic fire stem option is used, the ated from other spaces by partitions and doors. Doors and non-rated or field-applied that do not exceed 48 bottom of the door are 3.2.1 ervation and interview, I to ensure 1 of 15 doors as areas, such as rooms eaters, automatically into the door frame. This e could affect any visitor in the vicinity of oom adjoining the ce.  : ation with the pervisor during a tour of 10:30 a.m. to 12:35 p.m.	K00		K 029 NFPA 101 LIFE SAFET CODE STANDARD  One hour fire rated construction (with 3/4 hour fire-rated doors) of an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the area are separated from other space by smoke resisting partitions and doors. Doors are self-closing a non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	as es end and	06/05/2012
		<del>-</del>			There were no residents cited in rega	ard	

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Event ID: 005021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETED			COMPLETED
		155166	B. WIN			05/17/2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			606 WA		
VAI PAR	AISO CARE AND R	EHABILITATION CENTER	VALPARAISO, IN 46383			
			1			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	DATE
TAG		· · · · · · · · · · · · · · · · · · ·	+	IAG	to this regulation.	DATE
		ose and latch into the				
		ed on interview at the			How will you identify other	
		on, the Maintenance			residents having the potentia	ıl
	Supervisor ackno	owledged the entry door			to he affected by the same	
	to the mechanica	l room adjoining the			deficient practice and what	
	Respiratory Offic	ce drags on the floor			corrective action will be take	n?
	which causes the	entry door to not			All Decidents staff and visitors have	tho
		ose and latch into the			All Residents, staff and visitors have potential to be affected by the allege	
	door frame.				deficient practice.	
	3.1-19(b)				What measures will be put in	to
	3.1-17(0)				place or what systemic	
					changes you will make to ensure that the deficient	
		ervation and interview,			practice does not recur?	
	_	to ensure 1 of 15 doors			practice does not recui :	
		is areas, such as storage			The mechanical room door ha	s
	rooms greater that	an fifty square feet in size			been repaired. An automatic	
	used to store con	nbustible materials, are			closure has been	
	provided with se	lf closing devices to			added to the Central Supply Storage Room. All hazardous areas will have	
	close and latch th	ne door into the door			automatic door closures.	
	frame. This defi	cient practice could				
		nt, staff or visitor in the			How will the corrective action(s) be monitored to ensure the deficient	•
	1	entral Supply storage			practice will not recur, i.e., what	
	room.	entral Supply Storage			quality assurance program will be	
	100111.				put into place?	
	TO: 1: : 1 1				Automatic closures are visually chec	ked
	Findings include	•			monthly and documented in the	
					Preventative Maintenance Manual. Executive Director will review the	ine
	Based on observa				Preventative Maintenance Manual	
	Maintenance Sup	pervisor during a tour of			monthly. Findings will be presented	to
	the facility from	10:30 a.m. to 12:35 p.m.			the Safety Committee for review.	
	on 05/17/12, the	access door to the				
	Central Supply s	torage room is not				
	1	self closing device to				
		to the door frame. The				
		torage room measures				
	i Cenuai Suppiy S	wrage room measures	1		1	1

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	OF CORRECTION  IDENTIFICATION NUMBER:  155166	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	— СОМ 05/1	e survey pleted 7/2012		
VALPAR	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	286 square feet and is used to store combustible boxes containing sanitary napkins, gloves and bandages. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Central Supply storage room measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a self closing device.  3.1-19(b)						

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Event ID: 005021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED 05/17/2012				
		155166	B. WIN			05/17/	2012
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND I	REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG K0064	NFPA 101	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
SS=F	LIFE SAFETY Of Portable fire exthealth care occurs. 19.3.  1. Based on obs	servation and interview,	K00	064	K064 NFPA 101 Life Safety Code Standard		06/05/2012
	_	d to ensure 11 of 26			Code Standard		
	portable fire ext year hydrostatic subjected to the procedures ever NFPA 10, Stand Extinguishers C deficient practic residents, staff a Findings include Based on observ Maintenance Su the facility from on 05/17/12, ele inspection sticked indicating the m	test were emptied and applicable maintenance y six years as required by lard for Portable Fire hapter 4-4.3. This e could affect all and visitors.			Portable fire extinguishers are provided in all health care occupancies in accordance wi 9.7.4.1 19.3.5.6, NFPA 10  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  There were no residents cited in reg to this regulation.  How will you identify other residents having the potentiat to he affected by the same deficient practice and what corrective action will be take.  All Residents, staff and visitors have potential to be affected by the allege deficient practice. The fire	th  ard  n? the d	
	August 2004. The were located by Wing MDS Office Cottage Dining the Cottage Nur Lounge, in the Folining Room, in Dining Room enat the back exit.	The fire extinguisher 's Room 103, by the East ice, by Room 130, in the Room, by Room 144, by se's Station, in the West Front Lobby, in the Main in the kitchen by the Main intrance and in the kitchen Based on interview at observations, the			extinguishers have been replaced at the placard has been placed above to K-class portable fire extinguisher.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Fire extinguishers will be serviand will be replaced as neede	to ced	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	01	COMPLETED
		155166	B. WING			05/17/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF	PROVIDER OR SUPPLIE	R		606 WA		
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPA	RAISO, IN 46383	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Maintenance Su	pervisor acknowledged it			an outside contractor.	
	has been more th	nan six years since the			How will the corrective action(s) be	e
	most recent six	year test was documented			monitored to ensure the deficient	
	for fire extinguis	shers in the			practice will not recur, i.e., what	
	aforementioned	locations.			quality assurance program will be put into place?	
	2.1.10(1.)				Fire extinguishers are visually check	
	3.1-19(b)				monthly by the Maintenance Superv and documented in the Preventative	:
	2. Based on obs	ervation and interview,			Maintenance Manual. The Executive Director will review the Preventative	
	the facility failed	d to maintain 1 of 1			Maintenance Manual monthly. Find	
	portable K-class	fire extinguishers in the			will be presented to the Safety Committee for review.	
	kitchen cooking	area in accordance with			Committee for review.	
	the requirements	s of NFPA 10, Standard				
	for Portable Fire	Extinguishers, 1998				
	Edition. NFPA	10, 2-3.2 requires fire				
	extinguishers pr	ovided for the protection				
	of cooking appli	ances using combustible				
	cooking media (	vegetable or animal oils				
	and fats) shall be	e listed and labeled for				
	Class K fires. N	IFPA 10, 2-3.2.1 requires				
	a placard shall b	e conspicuously placed				
	near the extingu	isher which states the fire				
		n shall be activated prior				
		extinguisher. Since the				
		uishing system will				
	_	out off the fuel source to				
		liance, the fixed system				
		ted before using a				
		inguisher. In this				
	_	table fire extinguisher is				
	_	otection. This deficient				
		ffect any staff or visitors				
	in the vicinity of	•				
			ı			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE  A. BUILDING  B. WING	01	COME	E SURVEY PLETED 7/2012
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREE 606 V	ET ADDRESS, CITY, STATE, ZIP CO WALL ST PARAISO, IN 46383	ODE	
VALPARA (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR Findings included Based on observed Maintenance Superscript Maintenance Superscript Superscript Based on O5/17/12, a plan conspicuously plan portable fire extifuse protection syprior to using the extinguisher. Based time of observation of conspicuously supervisor acknown of conspicuously supervisor acknown supervisor superv	ation with the pervisor during a tour of 10:30 a.m. to 12:35 p.m. lacard was not laced near the K- class nguisher which states the extens shall be activated as K-class portable fire lased on interview at the lon, the Maintenance owledged a placard was ly placed near the K-class ly placed near the K-class		PARAISO, IN 46383  PROVIDER'S PLAN OF CORR	OULD BE	(X5) COMPLETION DATE
	_	nguisher stating the fire n shall be activated prior ass portable fire				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETE			COMPLETED
		155166	B. WIN			05/17/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER					
<b>\/ΔΙΡΔΡ</b> .	AISO CARE AND R	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383			
	AISO CAILL AIND IX	ENABLITATION CENTER		VALIA		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
K0076 SS=E	NFPA 101 LIFE SAFETY Commedical gas storage protected in a Standards for He (a) Oxygen storage 3,000 cu.ft. are esparation.  (b) Locations for than 3,000 cu.ft. NFPA 99 4.3.1.1 Based on observations facility failed to oxygen storage a cubic feet is enclasseparation. LSC in fire barriers shatype with the apprating. Further, and doors to be self or closing in accord deficient practices staff and visitors oxygen storage a Findings include  Based on observation of the facility from on 05/17/12, the room contained for the staff and t	ation and interview, the ensure 1 of 2 liquid reas of greater than 3000 osed within a one hour 8.2.3.2.1 requires doors hall be of an approved propriate fire protection 3.2.3.2.1(b) requires fire closing or automatic lance with 7.2.1.8. This is e could affect residents, in the vicinity of the east and transfilling room.	K00	TAG	K076 NFPA 101 Life Safety Code Standard  Medical gas storage and administrat areas are protected in accordance w NFPA 99, Standards for Health Care Facilities.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  There were no residents cited in regulation.  How will you identify other residents having the potentiat to he affected by the same deficient practice and what corrective action will be take  All Residents, staff and visitors have potential to be affected by the allege deficient practice. An automatic door closure was added to the east oxyge storage room door.	DATE  06/05/2012  don ith  ard  the d r n
	provided with a s	self closing device.			What measures will be put in place or what systemic	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/17/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview at the time of observation, the Maintenance Supervisor acknowledged the east oxygen storage		changes you will make to ensure that the deficient practice does not recur?	
	room is not equipped with a self closing device on the door.		All hazardous areas will have autom door closures.	natic
	3.1-19(b)		How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	
			Automatic closures are visually cher monthly and documented in the Preventative Maintenance Manual. Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented the Safety Committee for review.	The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPL	ETED
		155166	B. WIN		<del></del>	05/17/	2012
			Б. <b>ү</b> ү н ү	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
VALPAR	AISO CARE AND R	EHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383				
(X4) ID	CLIMMA DV C	TATEMENT OF DEFICIENCIES	<del></del>	ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K0143	NFPA 101			1110			5.112
SS=E	_	ODE STANDARD					
00 L	Transferring of o						
	, and the second	7.0					
		m any portion of a facility					
		are housed, examined, or					
		aration of a fire barrier of					
	1-hour fire-resist	ive construction;					
	(b) in an area tha	at is mechanically ventilated,					
		has ceramic or concrete					
	flooring; and						
		sted with signs indicating that					
	_	curring, and that smoking in rea is not permitted in					
		NFPA 99 and the					
		s Association. 8.6.2.5.2					
	· ·	ation and interview, the	K01	43	K143 NFPA 101 Life Safety		06/05/2012
		ensure the 1 of 2 liquid			Code Standard		
		ng areas was equipped					
	with a door with				Transferring of oxygen is: (a) separa from any portion of a facility wherein		
		g device. LSC 8.2.3.2.1			patients are housed, examined, or		
	· · · · · · · · · · · · · · · · · · ·	fire barriers shall be of			treated by a separation of a fire barri of 1-hour fire-resistive construction;	er	
	•	e with the appropriate fire			or 1-nour life-resistive construction,		
	11 31	** *			(b) in an area that is mechanic	ally	
		Further, 8.2.3.2.1(b)			ventilated, sprinklered, and ha	s	
	-	rs to be self closing or			ceramic or concrete flooring; a	ınd	
	1	g in accordance with			(a) in an array	_	
		icient practice could			<ul><li>(c) in an area posted with sign indicating that transferring is</li></ul>	S	
	,	staff and visitors in the			occurring, and that smoking in	the	
	vicinity of the ea	st oxygen storage and			immediate area is not permitte		
	transfilling room				in accordance with NFPA 99 a		
					the Compressed Gas		
	Findings include	<u>.</u>			Association. 8.6.2.5.2		
					What corrective action(s) wil	I	
	Based on observa	ation with the			be accomplished for those	-	
		pervisor during a tour of			residents found		
	Transcondince Sup	of their during a tour of			to have been affected by the		

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	OF CORRECTION  OF CORRECTION  155166	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/17/2012		
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, the east oxygen storage and transfilling room contained four liquid oxygen canisters and the transfilling room door is not provided with a self closing device on the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the east oxygen storage and transfilling room is not equipped with a self closing device on the door.  3.1-19(b)		There were no residents cited regard to this regulation.  How will you identify other residents having the potentito he affected by the same deficient practice and what corrective action will be take.  All Residents, staff and visitor have the potential to be affect by the alleged deficient practic An automatic door closure was added to the east oxygen storroom.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  An automatic door closure was added to the east oxygen storroom door. All hazardous are will have automatic door closures.  How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place?  Automatic closures are visual checked monthly and documented in the Preventati Maintenance Manual. The	al en? es ded dee. es rage nto es try out		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155166	(X2) MULTIPLE CO A. BUILDING B. WING	01		ESURVEY LETED 7/2012	
NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  606 WALL ST  VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	ALSO ZITORI OR			Executive Director wi Preventative Mainten monthly. Findings will be the Safety Committee for	II review the ance Manual presented to		

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STATEMENT OF DEFICIENCIES		XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION				LDING	01	COMPLETED
155166		B. WIN			05/17/2012	
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				606 W		
VALPARAISO CARE AND REHABILITATION CENTER					RAISO, IN 46383	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG			TAG		DEFICIENCY)	DATE
K0144	NFPA 101					
SS=F	LIFE SAFETY C	ODE STANDARD				
		nspected weekly and				
		load for 30 minutes per				
		ance with NFPA 99.				
	3.4.4.1.					0 < 10 7 10 0 1 0
	Based on record	review and interview, the	K01	144	K144 NFPA 101 Life Safety Code Standard	06/05/2012
	facility failed to	ensure emergency power			Standard	
	would be transfe	rred to the emergency			Generators are inspected weekly an	d
	generator within	10 seconds of building			exercised under load for 30 minutes	per
	_	2 of 12 months. NFPA			month in accordance with NFPA 99. 3.4.4.1.	
	•				3.4.4.1.	
	99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the				What corrective action(s) wil	I
					be accomplished for those	
		e minimum frequency			residents found to have beer	1
	_	lity requirements of the			affected by the deficient	
		m within 10 seconds after			practice?	
	loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection,				There were no residents cited in reg	ard
					to this regulation.	
	performance, exe	ercising period and				
	repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff				How will you identify other	
					residents having the potentia	al
					to he affected by the same	
					deficient practice and what corrective action will be take	m2
					Corrective action will be take	"'
and visitors.					All Residents, staff and visitors have	the
					potential to be affected by the allege	
	Findings include	:			deficient practice. The transfer time be logged weekly on the Emergency	
					Generator – Weekly Exercise/Month	l l
	Based on review	of "Emergency			Load Test Log.	
	Generator - Wee	kly Exercise/Monthly				
	Load Test Log" o	documentation with the			What measures will be put in	to
		pervisor during record			place or what systemic	
		a.m. to 10:30 a.m. on			changes you will make to ensure that the deficient	
	05/17/12, month				practice does not recur?	
	· · · · · · · · · · · · · · · · · · ·	or the twelve month			The transfer time will be logge	d
					weekly on the Emergency	-
	period from 05/1	6/11 through 04/16/12			Generator – Weekly	

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	<u> </u>	ICATION NUMBER:	A. BUILDING  B. WING	01	COMPLETED 05/17/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABIL	ITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEN	BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	lists the "Transfer Time generator ran in minutes test, but not how long it power to the emergency on interview at the time the Maintenance Supervacknowledged monthly documentation for "Tran not record how long it to power to the emergency each monthly load test.  3.1-19(b)	" as how long the s for each load took to transfer generator. Based of record review, risor load test asfer Time" does book to transfer		Exercise/Monthly Load Test Lo The Emergency Generator log will be reviewed by the Execut Director monthly.  How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be pri into place?  The Executive Director will rev the Preventative Maintenance Manual monthly. Findings will presented to the Safety Committee for review.	ty ut

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		A. BUILDING  B. WING  STREET A DDRESS CITY STATE ZIP CODE		01	(X3) DATE SURVEY COMPLETED 05/17/2012		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST				
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0147 SS=E	Electrical wiring a accordance with Electrical Code. Based on observer facility failed to including powers multiplug adapte substitute for fixed Article 400-8 recipermitted, flexib not be used as a swiring of a struct practice could rein the vicinity of Findings include Based on observer Maintenance Supthe facility from on 05/17/12, and Room 246 was pand not directly in on interview at the Maintenance acknowledged the	ention and interview, the ensure extension cords strips and nonfused as a ed wiring. NFPA 70, quires, unless specifically le cords and cables shall substitute for fixed cure. This deficient sidents, staff and visitors resident Room 246.  Ention with the pervisor during a tour of 10:30 a.m. to 12:35 p.m. electric bed in resident lugged into a power strip into a wall outlet. Based the time of observation, Supervisor e electric bed in resident lugged into a power strip electric bed in resident lugged into a power strip electric bed in resident lugged into a power strip	KO	47	K147 NFPA 101 Life Safety Code Standard  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice?  The power strip was immediately removed from Room 246.  How will you identify other residents having the potentiat to he affected by the same deficient practice a what corrective action will be taken?  All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  All staff will be re-educated on power strip usage by the Maintenance Supervisor/designee by June 19 10 10 10 10 10 10 10 10 10 10 10 10 10	I n al and e s ed ce.	06/05/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	COMPLETED 05/17/2012
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	606 W	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
				2012. The Customer Care Representatives and nurses make rounds daily and will for power strip usage.	
				How will the corrective action(s) be monitored to ensure the deficient practi will not recur, i.e., what qu assurance program will be into place?	ality
				The "Environmental Safety" tool will be utilized weekly x weeks then monthly ongoin The results will be by the Executive Director and presto the Quality Assurance Committee for review.	9.

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